Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: TEXOMA MEDICAL CENTER 3255 WEST PIONEER PARKWAY ARLINGTON TEXAS 76013	MFDR Tracking #: M4-09-5162-01
Respondent Name and Box #: TEXAS ASSOCIATION OF COUNTIES RMP REP BOX #: 01	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Since TDI moved to a 200% of MAR for outpatient services on 3/1/08 for hospital claims, we have reviewed the Medicare allowance and decided the insurance reimbursement does not meet this criteria…"

Principle Documentation:

1. DWC 60 package
2. Hospital or Medical Bill(s)
3. EOB(s)
4. Medical Reports
5. Total Amount Sought $352.70

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…The amount in dispute ($91.78) is based on the Provider's contention that reimbursement in the amount of $69.58 is owed for CPT 77003, and additional $5.00 for CPT 64484 and $17.20 for CPT code 64483. The Carrier contends that no additional reimbursement is owed…"

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Services in Dispute	Calculation	Amount in Dispute	Amount Due
09/18/2008	Hospital Outpatient Services	$568.67 (APC) + $0.00 (Outlier Amount) = $568.67 (OPPS) x 200% = $1,137.34 - $1,137.40 (Total paid by Respondent) = $0.00.	$352.70	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.403, titled ***Hospital Facility Fee Guideline – Outpatient,*** effective for medical services provided on or after March 1, 2008, set out the reimbursement guidelines for Hospital outpatient services.

This dispute was filed in the form and manner as prescribed by 28 TAC §133.307 and is eligible for Medical Dispute Resolution under 28 TAC §133.305 (a)(4).

1. The services listed in Part IV of this decision were denied or reduced by the Respondent with the following reason codes:
   Explanation of benefits with the listed date of audit 11/20/2008
   - W1 — Workers Compensation State Fee Schedule Adjustment.
   - 97 — Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 243 — The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
   - 5103 — The reimbursement used for establishing the MAR is the Medicare Facility Specific Amount, including Outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register.

   Explanation of benefits with the listed date of 12/18/2008
   - 18 — Duplicate claim/service.
   - 193 — Original payment decision is being maintained. This claim was processed properly the first time.
   - 247 — A payment or denial has already been recommended for this service.
   - 1014 — The attached billing ahs been re-evaluated at the request of the provider. Based on this re-evaluation we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
   - D1 — Duplicate Control Number 900015193.
2. The Respondent denied reimbursement for the outpatient services based upon duplicate claim/service. The disputed service was a duplicate bill submitted for reconsideration of payment. The Respondent did not provide information/documentation of duplicate payments. Therefore, this payment denial reason has not been supported. The Division acknowledges that the 'duplicate denial' code identifies/represents a re-audit of the claim form.
3. Rule 134.403 (e) states in pertinent part, "Regardless of billed amount, reimbursement shall be:

   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or

   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;…"
4. Pursuant to Rule 134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 200 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.
5. Upon review of the documentation submitted by the requestor and respondent, the Division finds that:

   (1) No contract exists;

   (2) MAR can be established for these services; and

   (3) Separate reimbursement for implantables was *NOT* requested by the requestor.
6. Consequently, reimbursement will be calculated in accordance with Rule §134.403 (f)(1)(A) as follows:

APC Value	Outlier Payment	Separate Reimbursement for implantables was NOT requested	APC + Outlier Payment X 200%	Subtract Amount Paid by Respondent	Results in additional Amount Due to Requestor
$568.67	$0.00	$0.00	$1,137.34	$1,137.40	$0.00

7. Based upon the documentation submitted by the parties and in accordance with Texas Labor Code Sec. 413.031 (c), the Division concludes that the requestor, Texoma Medical Center, is not due additional payment. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
28 TAC Rule §134.403
28 TAC Rule §133.307
28 TAC Rule §133.305

PART VII: DIVISION DECISION

The Division hereby ORDERS the respondent to remit to the requestor the amount of $0.00 regarding the services involved in this dispute.

Authorized Signature	Medical Fee Dispute Resolution Officer	August 17, 2009 Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.